UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM
TAMIFLU (Oseltamivir Phosphate)

Patient name:_____Medicaid or SS#_____

Physician Name:_____ Contact person:_____

Phone#:_____Extensions and

options_____Fax#_____

Pharmacy_____Pharmacy Phone#:_____

All information to be legible, complete and correct or form will be returned

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TELEPHONE AUTHORIZATION OR WRITTEN REQUEST

CRITERIA

Diagnosis of Influenza A or Influenza B with age > 1 year

Covered only for patients at high risk from diagnosed and documented disease states of immunodeficiency. The term "immunodeficient" includes: HIV/AIDS or other diseases that affect the immune system; long-term radiation treatment; long-term treatment with drugs such as steroids; oncology agents; immunosuppressive agents or fragility due to extreme age (greater than 65 years).

Limit: 10 capsules or tablets per year.

Prophylaxis for Influenza A or B with age > 13 years

Documentation must be provided that demonstrates that one other household member or residential member currently has documented influenza A or B.

Covered only for patients at high risk from diagnosed and documented disease states of:

a. severe cardiopulmonary conditions.
b. immunocompromised patients.
c. fragility due to extreme age (greater than 65 years).

Limit: 7 day treatment with 14 pills or tablets.

The Department regards adequate clinical records as essential for the delivery of quality care, such comprehensive records are key documents for post payment review. Your authorization certifies that the above request is medically necessary, meets the Utah Medicaid criteria for prior authorization, does not exceed the medical needs of the member and is supported in your medical records.

Physician Signature_____**Date of Submission**_____